

COMMENTARY

Debates on physician-assisted suicide are a barrier to real reforms in caring for patients

Life and its end are endlessly fascinating, complicated, and resistant to easy categorization. SW here does not do badly, despite some awkwardness in his care. What is it that Dr. Goodwin would have us learn from the story?

One lesson might be that SW and his family are the prelude to a set of patients who will demand equity and fair access to physician assistance in suicide. Why, after all, does living in a particular community bar one from having this option? If this change happens, it might also presage a gradual course toward ordinariness in physician assistance in suicide. We have few issues that routinely *do* trouble us, that remain troubling over years, and that are valued as persistently difficult. It would be unfortunate and demoralizing to allow the ending of a human life to become routine, even if one believes that the legalization of physician assistance in suicide is good policy. This story as it is told highlights the sacred, mystical, relational, and tender aspects of one life coming to an end. Nothing would be different about the law and public policy, however, if the family were cold-hearted, the patient were whining, the doctor were indifferent, and the course of care were quite mundane. Nevertheless, our intuitions about correctness of policy might well change.

Caregivers have to be careful to attend to the ordinariness of the details of dying, not just the grander poetic aspects. Yet, that very ordinariness is a real threat if good dying comes to include consideration of suicide. Why, after all, is it so important that the physician be involved—might it not in part be the mantra of acceptability granted by “the white coat”?

More important, however, is the terribly persistent fact that most of us do not get such good conditions in which to die. Our dying is much less predictable, our families (if we still have family members capable of giving care) are overwhelmed, our finances are ruined, and our capabilities of self-direction are long since lost. We need to make public

policy for these deaths, too. I continue to believe that the most troubling public policy aspect of legalizing physician assistance in suicide is that those who already have so little from the community—the poor, the disabled, the chronically ill—will come to be expected to leave this life willingly when it is convenient for society. It will still be their “choice”—but it might often be the only choice widely accepted by friends and family and might often be the only choice that avoids serious financial and emotional burdens to loved ones. That, it seems, is not a “choice” that warrants the label.

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Although it is particularly germane to the issue of physician-assisted suicide, Dr. Goodwin's essay uses a strange term with regard to the course of deciding to forgo nutrition and hydration: he suggests that the patient “starve to death.” The very phrase implies that the patient is feeling great hunger. In fact, most people who are so sick that they will die soon also have very little appetite. Especially with cancer and its attendant weight loss, SW is likely to have been ketotic and dehydrated before making any choice to stop eating and drinking. According to the reports of hundreds of such patients, they experience no hunger and little thirst, so long as the mouth is kept moist. They find it odd to have the day no

longer marked by meals—but they do not feel hungry. While they do become more chemically abnormal, that is not a felt experience. Thus, I would never use the term “starve to death.”

In sum, SW died pretty much as most people do when they die of a somewhat predictably overwhelming cancer and get good hospice care. They die comfortably. They and their families find the opportunities that they need for closure and meaning. They leave their families with good memories and tolerable bereavement. His time to dying was probably affected very little by his decision to stop eating. His dying might or might not have been different with lethal pills in the closet. Even if he never took them, he might have been tormented by the continual presence of a decision as to what to do.

We are just learning our way as a culture in this new era of having the opportunity to grow old and die slowly. We do not have settled language or categories. We do not know yet what to admire and what to avoid. Certainly all of us mortals need reliably good care, more appropriate financing, and more comprehensive support of families. We need aggressive quality improvement and a commitment to policy reform. Physician-assisted suicide is not the most important issue confronting us. Let us make good care sufficiently comprehensive and reliable so that people no longer fear their care system. Then debates on physician-assisted suicide would be interesting. Now they are both barriers to the real reforms needed and a persistent threat to those whom society sees so often as the unappealing victims of serious chronic illness.

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